Texas Department of Insurance, Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1609

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Requestor's Name and Address: Ferral L. Endsley, D.O. 1934 Hickory Ste. 100 Abilene, TX 79601	MFDR Tracking #: M4-08-3552-01 DW Injured Dat
Respondent Name and Box #: Everest National Insurance Co. Rep. Box #: 11	Empl Insuranc

PART II: REQUESTOR'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Requestor's Position Summary: "...The insurance carrier instructed our office to send medical bills to them via fax @ 972-378-0598 and/or 859-258-2097, which we have done several times. We have sent the claims via fax at least 8X. I have attached the fax transmission verifications."

Principle Documentation:

1. DWC 60 package
2. Total Amount Sought - $536.18
3. CMS 1500s
4. EOBs
5. Fax confirmation sheets

Sent
APR 23 2008
TX DEPARTMENT OF INSURANCE
DIVISION OF WORKERS'
COMPENSATION

PART III: RESPONDENT'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Respondent's Position Summary: No response submitted

Principle Documentation:

1. N/A

PART IV: SUMMARY OF FINDINGS

Eligible Dates of Service (DOS)	CPT Codes and Calculations	Denial Codes	Part V Reference	Amount Ordered
08/02/07	CPT Code 99203 ($86.76 x 125%)	No EOBs	1, 2, 5	$108.45
08/02/07	CPT Code 99080-73	No EOBs	1,3, 5	$ 15.00
08/10/07	CPT Code 99212 ($34.15 x 125%)	No EOBs	1, 2, 5	$ 42.69
09/10/07	CPTCode 99455-V3-WP	No EOBs	1, 4, 5	$370.04
Total Due:				$536.18

PART V: REVIEW OF SUMMARY, METHODOLOGY AND EXPLANATION

Texas Labor Code Section 413.011(a-d), titled *Reimbursement Policies and Guidelines*, and Division Rule 134.202, titled *Medical Fee Guideline* for professional medical services on or after August 1, 2003, set out the reimbursement guidelines.

1. Neither party submitted EOBS. Per Division Rule at 28 Texas Administrative Code 133.307(c)(2)(B) the Requestor has submitted convincing evidence in the form of fax confirmation sheets to support reconsideration and request for an EOB; therefore, the disputed services will be review per Division Rules.

2. Per 28 Texas Administrative Code 134.202(b) and (c)(1) reimbursement for CPT Codes 99203 and 99212 are recommended.
3. Per 28 Texas Administrative Code 129.5(i) reimbursement for CPT Code 99080-73 is recommended.
4. Per 28 Texas Administrative Code 134.202(e)(6)(C)(i) and (D)(iii)(II)(b)(1) is recommended.
5. Per review of Box 32 on CMS-1500, zip code 75237 is located in Dallas County. The maximum reimbursement amount, under Rule 134.202(b), is determined by locality.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES

Texas Labor Code Section. 413.011(a-d), Section. 413.031 and Section. 413.0311
28 Texas Administrative Code Section. 129.5, 133.307, 134.1, Section. 134.202
Texas Government Code, Chapter 2001, Subchapter G

PART VII: DIVISION DECISION

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Section 413.031, the Division has determined that the Requestor is entitled to reimbursement. The Division hereby **ORDERS** the Carrier to remit to the Requestor the amount of $536.18 plus applicable accrued interest per Division Rule 134.130, due within 30 days of receipt of this Order.

ORDER:

Authorized Signature

Marguerite Fo[redacted]
Medical Fee Dispute Resolution Officer

April 22, 2008
Date

PART VIII: YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in Division Rule 148.3(c).

Under Texas Labor Code Section 413.0311, your appeal will be handled by a Division hearing under Title 28 Texas Administrative Code Chapter 142 Rules if the total amount sought does not exceed $2,000. If the total amount sought exceeds $2,000, a hearing will be conducted by the State Office of Administrative Hearings under Texas Labor Code Section 413.031.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.